Physical Therapy

Which providers are eligible to provide physical therapy?
[Refer to WAC 388-545-500(1)]

- Licensed physical therapists or physiatrists; or
- Physical therapist assistants supervised by licensed physical therapists.

Where must physical therapy services be provided?
[WAC 388-545-500(3)(a)(f)]

The Department pays eligible providers for physical therapy services provided as part of an outpatient treatment program in the following settings:

- In an office, home, or outpatient hospital setting;

> **Note**: Physical therapy may be performed by a home health agency as described in Chapter 388-551 WAC, or as part of an acute physical medicine and rehabilitation (Acute PM&R) program as described in Acute PM&R subchapter 388-550 WAC.

- In a neurodevelopmental center;
- In a school district or educational service district facility as part of an individual education plan (IEP) or individualized family service plan (IFSP), as described in WAC 388-537-0100; or
- For children two years of age and younger with disabilities, in natural environments including the home and community settings in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

Referral and Documentation Process

Adults (Age 21 and older) **[Refer to WAC 388-545-500 (5)]**

Providers must document in a client's medical record that physical therapy services provided to clients age 21 and older are medically necessary. Such documentation may include justification that physical therapy services:

- Prevent the need for hospitalization or nursing home care;
- Assist a client in becoming employable;
- Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or

- Are part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

Children (Age 20 and younger)

The EPSDT screening provider must:

- Determine if there is a medical need for physical therapy; and
- Document the medical need and the referral in the child's medical record.

The provider must:

- Keep referral information on file in the form of a prescription, notes from telephone calls, etc.;
- Contact the referring EPSDT provider for information concerning the need for physical therapy services; and
- Keep the referring and/or continuing care provider apprised of the assessment, prognosis, and progress of the referred child.

Coverage [WAC 388-545-500(4)]

The Department pays providers for only those covered physical therapy services listed in this section when they are:

- Within the scope of an eligible client's medical care program;
- Medically necessary and ordered by a physician, physician assistant, or an ARNP;
- Begun within 30 days of the date ordered;
- For conditions which are the result of injuries and/or medically recognized diseases and defects; and
- Within accepted physical therapy standards.

> **Note**: The Department does not limit covered physical therapy services for clients 20 years of age and younger.

Coverage for adults (age 21 and older) **[Refer to WAC 388-545-500 (8)]**

The Department covers without prior authorization the following physical therapy services per client, per diagnosis:

- One physical therapy evaluation (in addition to the 48 program unit limitation below) per calendar year;
- 48 physical therapy program units per calendar year;
- Two DME needs assessments per calendar year (in addition to the 48 program units). Two 15-minute units are allowed per DME needs assessment; and
- One wheelchair needs assessment per calendar year (in addition to the two DME needs assessment). Four 15-minute units are allowed per wheelchair assessment).

The Department covers up to 96 physical therapy program units per calendar year *in addition* to the original 48 units only when:

- The client is diagnosed with one of the following conditions:

ICD-9-CM Diagnosis Codes	Condition
315.31-315.9, 317-319	**Medically necessary conditions for individuals identified as having developmental disabilities**
343.0 - 343.9	Cerebral palsy
741.90-741.93	Meningomyelocele
758.0	Down syndrome
781.2 - 781.3	Symptoms involving nervous and musculoskeletal systems, lack of coordination
800.00 - 829.1	Surgeries involving extremities – Fractures
851.00 - 854.19	Intracranial injuries
880.00 - 887.7	Surgeries involving extremities - Open wounds with tendon involvement
941.00 - 949.5	Burns
950.0 - 957.9, 959.01 - 959.9	Traumatic injuries

Note: The conditions above **must** be listed as the primary diagnosis on the claim.

-OR-

- The client no longer needs nursing services, but continues to require specialized outpatient physical therapy following an approved Acute PM&R stay within the previous 12 months for the following conditions:

ICD-9-CM Diagnosis Codes	Condition
854.00-854.19	Traumatic brain injury
900.82, 344.00- 344.09, 344.1	Spinal cord injury (paraplegia and/or quadriplegia)
436	Recent or recurrent stroke
340	Restoration of the levels of function due to secondary illness or loss for multiple sclerosis
335.20	Amyotrophic lateral sclerosis
343.0 – 343.9	Cerebral palsy
357.0	Acute infective polyneuritis (Guillain-Barre' syndrome)

(continued on next page…)

(Continued from previous page…)

ICD-9-CM Diagnosis Codes	Condition
941.40-941.49, 941.50-941.59, 942.40-942.49, 942.50-942.59, 943.40-943.49, 943.50-943.59, 944.40-944.48, 944.50-944.58, 945.40-945.49, 945.50-945.59, 946.4, 946.5	Extensive severe burns
344.00-344.09, 707.00-707.09	Skin flaps for sacral decubitus for quads only
890.0 - 897.7, 887.6 - 887.7	Open wound of lower limb, bilateral limb loss

Physical Therapy Program Limitations

The Department does not cover duplicate services for occupational and physical therapy for the same client when both providers are performing the same or similar procedure(s).
[WAC 338-545-500 (11)]

> **Note**: A program unit is based on the CPT® code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes. If time is included in the CPT description, the beginning and ending times of each therapy modality must be documented in the client's medical record.

The following are considered part of the physical therapy program 48-unit limitation:

- Application of a modality to one or more areas not requiring direct patient contact (CPT codes 97010-97028).
- Application of a modality to one or more areas requiring direct patient contact (CPT codes 97032-97039).
- Therapeutic exercises (CPT codes 97110-97139).
- Manual therapy (CPT code 97140).
- Therapeutic procedures (CPT code 97150).
- Prosthetic training (CPT code 97761).

- Therapeutic activities (CPT code 97530).
- Self-care/home management training (CPT code 97535).
- Community/work reintegration training (CPT code 97537).
- Physical performance test or measurement (CPT code 97750). Do not use to bill for an evaluation (CPT code 97001) or re-evaluation (CPT code 97002).
- Assistive technology assessment (CPT code 97755).

The following are not included in the physical therapy program 48-unit limitation:

- Muscle testing (CPT codes 95831-95852). The Department covers one muscle testing procedure per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical therapy CPT codes.
- Physical therapy evaluation (CPT code 97001). Use for reporting the initial evaluation before the plan of care is established by the physical therapist or the physician. This procedure is not used for re-evaluating the client's condition and establishing the plan of care.
- Physical therapy re-evaluation (CPT code 97002). Allowed once per client, per calendar year. Use for reporting the re-evaluation of a client who has been under a plan of care established by a physician or physical therapist. This procedure is for re-evaluating the client's condition and revising the plan of care under which the client is being treated.
- Cognitive testing (CPT code 96125). Allowed once per client, per calendar year.
- Orthotics fitting and training upper and/or lower extremities (CPT code 97760). The Department covers two units per day. This procedure can be billed alone or with other physical therapy CPT codes.
- Active wound care management involving selective and non-selective debridement (CPT codes 97597, 97598, and 97602). The following conditions apply:
  - ✓ The Department covers one unit of CPT code 97597, 97598, and 97602 per client, per day, per wound. Providers may not bill CPT codes 97597, 97598, and 97602 in conjunction with each other for the same wound; however, CPT codes 97597, 97598, and 97602 may be billed in conjunction with each if they are for separate wounds.
  - ✓ Providers must not bill CPT codes 97597, 97598, and 97602 in addition to CPT codes 11040-11044.

Note: For multiple wounds, use modifier 59.

- Checkout for orthotic/prosthetic use (CPT code 97762). The Department covers two 15-minute units per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Wheelchair management (CPT code 97542).

- Wheelchair needs assessment (CPT code 97542). The Department covers one wheelchair needs assessment per client, per calendar year, limited to four 15-minute units per assessment. Indicate on the claim that this is a wheelchair needs assessment.

- DME needs assessments (CPT code 97762). The Department covers two DME needs assessments per client, per calendar year, limited to two 15-minute units per assessment. Indicate on the claim that this is a DME needs assessment.

- Splints (refer to Section K for those splints covered in a provider's office).

How do I request approval to exceed the limits?

For clients 21 years of age and older who need physical therapy in addition to existing program unit limitations, the provider must request a Limitation Extension (LE). See Section I – Prior Authorization.

Are school medical services covered?

The Department covers physical therapy services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to the Department/MPA *School-Based Healthcare Services Billing Instructions*. (See Important Contacts.)

What is not covered? [WAC 388-545-500(12)]

The Department does not pay separately for physical therapy services that are included as part of the payment for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

Miscellaneous Services

Acute Physical Medicine and Rehabilitation (Acute PM&R): Inpatient PM&R is limited to Department-contracted facilities.

DDD Physical: The Department covers one physical every 12 months for clients with disabilities. Use HCPCS code T1023 with modifier HI and an ICD-9-CM diagnosis code from the range V79.3-V79.9 to bill for an annual exam.

HIV/AIDS Counseling: The Department covers two sessions of risk factor reduction counseling (CPT code 99401) counseling per client, each time tested. **[Refer to WAC 388-531-0600]** Use ICD-9-CM diagnosis code V65.44 when billing CPT code 99401 for HIV/AIDS counseling. The Department does not pay for HIV/AIDS counseling when billed with an E&M service unless the client is being seen on the same day for a medical problem and the E&M service is billed with a separately identifiable diagnosis code and with modifier 25.

Needle Electromyography (EMGs): The Department has adopted Medicare-established limits for billing needle EMGs (CPT codes 95860 – 95870) as follows:

CPT Code	Brief Description	Limits
95860 95861 95863 95864	Needle EMG; one extremity with or without related paraspinal areas **two extremities…** **three extremities…** **four extremities…**	• Extremity muscles innervated by three nerves or four spinal levels must be evaluated with a minimum of five muscles studied.
95865	Muscle test, larynx	• Limited to one unit per day.
95866	Muscle test, hemidiaphragm	• Limited to one unit per day.
95869	Needle EMG; thoracic paraspinal muscles	• Limited to one unit per day. • For this to pay with extremity codes 95860-95864, test must be for T3-T11 areas only; T1 or T2 alone are not separately payable.
95870	Needle EMG; other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters	• Limited to one unit **per extremity**, and one unit for cervical or lumbar paraspinal muscle, regardless of number of levels tested (maximum of 5 units). • Not payable with extremity codes (CPT codes 95860-95864).

Nerve Conduction Study (NCS):

CPT Code	Brief Description	Limits
95900, 95903, and 95904	Nerve Conduction Study	Each nerve constitutes one unit of service

TB Treatment Services: The E&M codes 99201-99215 are for office visits only, and must be billed for professional providers such as physicians (or nursing staff under a physician's supervision), Advanced Registered Nurse Practitioners (ARNPs), and Physician Assistants (PAs).

When billing for TB treatment services provided by professional providers in the client's home, Health Departments may also bill CPT codes 99341 and 99347.

TB Treatment Services Performed by Non-Professional Providers: Health Departments billing for TB treatment services provided by **non-professional providers** in either the client's home or in the office must bill using HCPCS code T1020 (personal care services). Do not bill the initial visit with a modifier. Follow-up visits must be billed using T1020 with modifier TS (follow-up services modifier). Use one of the following ICD-9-CM diagnosis codes:

Diagnosis Code	Description
010.00 – 018.96	Tuberculosis infections
795.5	Nonspecific reaction to tuberculin skin test
V01.1	Tuberculosis
V71.2	Observation for suspected tuberculosis
V74.1	Pulmonary tuberculosis

Irrigation of Venous Access Pump

CPT code 96523 may be billed as a stand-alone procedure. However, if billed by the same provider/clinic on the same day as an office visit, you must use modifier 25 to report a separately identifiable medical service. If you do not use modifier 25, the Department will deny the E&M code.

Ultraviolet Phototherapy

The Department does not cover ultraviolet phototherapy (CPT code 96910) when billed with ICD-9-CM diagnosis code 709.01 (vitiligo). The Department considers this a cosmetic procedure.

Artificial Disc Replacement

- The Department will require prior authorization for **cervical** disc replacement CPT codes 22856 and 22861 (refer to Section I). The basis for coverage/noncoverage is as follows:

  ✓ Clients must meet the following Federal Drug Administration (FDA)-approved indications for use and not have any contra-indications. FDA approval is device-specific, but includes:

  - Skeletally mature patient.
  - Reconstruction of a disc following single-level discectomy for intractable symptomatic cervical disc disease (radiculopathy or myelopathy) confirmed by patient findings and imaging.

  ✓ Clients cannot have any of the following FDA general contra-indications:

  - Infection - active systemic or at the site of implantation.
  - Any allergy or sensitivity to implant materials.
  - Certain bone and spine diseases (e.g., severe spondylosis or marked cervical instability).

  ✓ Non FDA-approved uses are noncovered.

- The Department will require prior authorization for **lumbar** disc replacement CPT codes 22857, 22862, and 22865 (refer to Section I).

Collagen Implants

The Department pays for CPT code 51715 and HCPCS codes L8603 and L8606 only when the diagnosis code is 599.82 (Intrinsic sphincter deficiency). See Section K for limitations.

Ventilator Management

E&M services are not allowed in combination with CPT codes 94002 - 94004, 94660, and 94662 for Ventilator Management on the same day, by the same provider/clinic. However, E&M services may be billed for on the same date of service using modifier 25 to indicate that a significant and separately identifiable service was provided. If modifier 25 is not used, the Department will deny the E&M code.

Cochlear Implant Services [Refer to WAC 388-531-0200(4) (c)]

Bilateral cochlear implants require prior approval and may be approved for pre-lingual children. Unilateral cochlear implantation (CPT code 69930) requires EPA (see section I). If a client does not meet the EPA criteria or you are requesting bilateral cochlear implantation for pre-lingual children, PA is required.

The Department covers replacement parts for cochlear devices through the Department/MPA Hearing Aids and Services Program ***only***. The Department pays only those vendors with a current core provider agreement that supply replacement parts for cochlear implants and bone-anchored hearing aids (BAHA).

Vagus Nerve Stimulation (VNS) [Refer to WAC 388-531-0200(h)]

- Vagus nerve stimulation (CPT codes 61885, 61886, 61888 and 64573) requires prior authorization (refer to Section I - Prior Authorization).
- VNS procedures can be performed in an inpatient hospital or outpatient hospital setting.
- Prior authorization is not required for VNS programming (CPT codes 95970, 95974, and 95975) performed by a neurologist.
- The Department does not pay for VNS and related procedures for a diagnosis of Depression (CPT 64550-64565, 64590-64595, 95970, 95974, and 95975).

Osseointegrated Implants

- Insertion or replacement of osseointegrated implants (CPT codes 69714-69718) requires prior authorization (refer to Section I - Prior Authorization).
- The procedure can be performed in an inpatient hospital setting or outpatient hospital setting.

The Department covers replacement parts for BAHA through the Department's Hearing Aids and Services Program ***only***. The Department pays only those vendors with a current core provider agreement that supply replacement parts for cochlear implants and BAHA.

Limitations on coverage for certain miscellaneous procedures are listed below:

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
11980	Implant hormone pellet(s)	257.2 and 174-174.9
S0139	Minoxidil, 10 mg	401.0-401.9 (essential hypertension)
S0189	Testosterone pellet 75 mg	257.2, 174.0-174.9 and only when used with CPT code 11980

Outpatient Cardiac Rehabilitation

Eligible programs:

- CNP;
- Children's Health;
- LCP-MNP (only clients 20 years of age and younger);
- GAU; and
- GAU-ADATSA.

The Department covers outpatient cardiac rehabilitation in a hospital outpatient department for eligible clients who:

- Are referred by a physician;
- Have coronary artery disease (CAD);
- Do not have specific contraindications to exercise training; and
- Have:
  - ✓ A recent documented history of acute myocardial infarction (MI) within the preceding 12 months;
  - ✓ Had coronary angioplasty (coronary artery bypass grafting [CABG];
  - ✓ Percutaneous transluminal coronary angioplasty [PTCA]); and/or
  - ✓ Stable angina.

Bill physician services with procedure code 93798 or G0422 that includes continuous ECG monitoring (per session) with one of the following diagnosis codes:

- 410.00-410.92 (Acute myocardial infarction);
- 413.0-413.9 (Angina pectoris);
- V45.81 (Aortocoronary bypass status);
- V45.82 (Percutaneous transluminal coronary angioplasty status); or

> **Note:** Cardiac rehabilitation does not require PA, and it is only approved for the above diagnoses.

The Department **does not** cover procedure code 93797 or G0423.

The outpatient cardiac rehab program hospital facility must have all of the following:

- A physician on the premise at all times, and each client is under a physician's care;
- Cardiopulmonary emergency equipment and therapeutic life-saving equipment available for immediate use;
- An area set aside for the program's exclusive use while it is in session;
- Personnel who are:
  - ✓ Trained to conduct the program safely and effectively;
  - ✓ Qualified in both basic and advanced life-support techniques and exercise therapy for coronary disease; and
  - ✓ Under the direct supervision of a physician;
- Non-physician personnel that are employees of the hospital;
- Stress testing:
  - ✓ To evaluate a patient's suitability to participate in the program;
  - ✓ To evaluate chest pain;
  - ✓ To develop exercise prescriptions; and
  - ✓ For pre and postoperative evaluation of coronary artery bypass clients;
- Psychological testing or counseling provided if a client:
  - ✓ Exhibits symptoms such as excessive fear or anxiety associated with cardiac disease; or
  - ✓ Has a diagnosed mental, psychoneurotic, or personality disorder; and
- Continuous cardiac monitoring during exercise or ECG rhythm strip used to evaluate a client's exercise prescription.

The Department covers up to 24 sessions (usually 3 sessions a week for 4-6 weeks) of cardiac rehab exercise sessions (phase II) per event. The clients must have continuous ECG monitoring. The Department covers continued participation in cardiac rehab exercise programs beyond 24 sessions only on a case-by case basis with preauthorization.

Diabetic Education (HCPCS Code G0108 and G0109) [WAC 388-550-6300]

- The Department pays for up to 6 hours of diabetic education/diabetic management per client, per calendar year.

- Certified diabetic education providers must be approved by the Department of Health (DOH). Contact the number provided below to receive a list of DOH approved diabetic education providers.

- All physicians, ARNP's, clinics, hospitals, and Federally Qualified Health Centers are eligible to apply to be a diabetes education provider. The Diabetes Control Program (DCP) at DOH develops the application criteria and evaluates all applications for this program.

- A minimum of 30 minutes of education/management must be provided per session.

- Diabetes education may be provided in a group or individual setting, or a combination of both, depending on the client's needs.

Note: The Department does not reimburse for diabetes education if those services are an expected part of another program provided to the client (e.g. school-based health services or adult day health services).

For more information on becoming a diabetes education provider and to obtain an application, write or call:

Diabetes Prevention and Control Program
Department of Health
PO Box 47855
111 Israel Rd SE
Tumwater, WA 98501
1-253- 395-6758

Note: Please refer to the Department/MPA *Diabetic Education Billing Instructions* for more information.

Group Clinical Visits for Clients with Diabetes or Asthma

Overview of the Program

The intent of the Diabetes and Asthma Group Clinical Visits program is to provide clinical services and educational counseling to Department clients who have been diagnosed with diabetes or asthma. These visits are limited to groups of two or more clients and are payable only to physicians or advanced registered nurse practitioners (ARNPs). However, participation from other professional staff, including physician assistants, physical therapists, nurses, and nutritionists, is encouraged.

Program Requirements

- Prior to a group clinical visit, the provider must perform an assessment of individual client medical information and document the proposed treatment plan for each client.

- The group clinical visit must be led by a physician or ARNP, but may include other staff as well.

- The group clinical visit must last at least one hour and include:

  - ✓ A group discussion on clinical issues to promote long-term disease control and self-management. This discussion should include at least one of the following topics:

    - ➢ Prevention of exacerbation or complications;
    - ➢ Proper use of medications and other therapeutic techniques (spacers, peak flow meter use; glucose measurement, foot care, eye exams, etc.); or
    - ➢ Living with a chronic illness;

  - ✓ A question and answer period;
  - ✓ The collection of prevention-based care data needed to monitor chronic illness (e.g., weight and blood pressure); and
  - ✓ Short (approximately 5-10 minutes per client) one-on-one visits to gather needed data and establish an individual management plan with the client.

- The following must be documented in the medical record:

  - ✓ Individual management plan, including self-management capacity;
  - ✓ Data collected, including physical exam and lab findings;
  - ✓ Patient participation; and
  - ✓ Beginning and ending time of the visit.

Billing and Reimbursement

Providers must use the following CPT code when billing for diabetes or asthma group counseling visits, subject to the limitations in the chart below. Providers must bill visits in increments of one-hour units (one hour = one unit). Multiple units may be billed on the same day.

CPT Code	Restricted to Diagnoses	Visit Limitations
99078	Diabetes: 250.00-250.93 Asthma: 493.00-493.92	Limited to four (4) one-hour units per calendar year, per client, per condition

Note: The Department pays only for the time that a client spends in the group clinical visit.

Other Limitations:

The Department does not reimburse a diabetes or asthma group clinical visit in conjunction with an office visit or other outpatient evaluation and management (E&M) codes for the same client, same provider, and same condition on the same day.

A diabetes group clinical visit may be billed on the same day as a Department of Health (DOH) - approved diabetes education core module as long as the times documented in the medical record indicate two separate sessions.

Hyperbaric Oxygen Therapy (CPT 99183)

Hyperbaric oxygen therapy requires EPA- see section I. If the client does not meet the EPA criteria, PA is required.

Genetic Counseling and Genetic Testing

The Department covers genetic counseling for all FFS adults and children when performed by a physician.

To bill for genetic counseling, use diagnosis code V26.33 genetic counseling and the appropriate E&M code.

Certain genetic testing procedure codes need PA. Physicians must obtain PA if required for certain genetic tests and must give both the PA number and the appropriate genetic testing modifier to the laboratory or when the laboratory bills so they can bill correctly.

> **Note:** DOH approved genetic counselors provide counseling for pregnant women (fee for service and healthy option clients) up to the end of the month containing the 60th day after the pregnancy ends. This service does not require authorization. To locate the nearest DOH-approved genetic counselor call DOH at 1-253-395-6742.

Out-of-State Hospital Admissions **(does not include border hospitals)**

The Department pays for emergency care at an out-of-state hospital, not including hospitals in bordering cities, only for Medicaid and SCHIP clients on an eligible program. See WAC 388-501-0175 for recognized bordering cities.

The Department requires PA for elective, non-emergency care and only approves these services when:

- The client is on an eligible program (e.g., the Categorically Needy Program); and
- The service is medically necessary and is unavailable in the State of Washington.

Providers requesting elective, out-of-state care must send a completed Out-of-State Medical Services Request Form, DSHS 13-787, with additional required documentation attached, to the Department Medical Request Coordinator (See *Important Contacts*).

Providers must obtain prior authorization from the appropriate MHD designee for **out-of-state psychiatric hospital admissions** for all Medicaid clients. Neither the Department nor the MHD designee pays for inpatient services for non-Medicaid clients if those services are provided outside of State of Washington. An exception is clients who are qualified for the General Assistance – Unemployable (GAU) program. For these clients, the Department and the MHD designee pays for inpatient psychiatric services provided in bordering cities and critical border hospitals. All claims for admissions to **out-of-state hospitals** are paid as **voluntary** legal status as the Involuntary Treatment Act applies only within the borders of Washington State.